

EXHIBIT A

**HIPAA Privacy Authorization
For Disclosure of Protected Health Information
Relevant to Litigation, Pending Claims or Intent to Sue**

Patient's Name: **Gerald Palmer Jr.**

Address: [REDACTED]

Date of Birth: [REDACTED]

1. I make this Authorization for the purpose of copying records in connection with a lawsuit or claim to which I am a party.
2. This authorization is directed to and applies to protected health information maintained by:

**Alliance Psychological Services
1135 W. University Dr. Suite 445
Rochester, MI 48307**

3. I hereby authorize the above, its director, administrative and clinical staff or assignees, medical information services and billing departments to release any and all medical, pharmacological, psychological, and/or therapy records, from December 11, 2014 to present, including but not limited to any and all records, information, documents related to treatment, evaluation, analysis or consultation, psychiatric and psychological records, psychotherapy notes, progress notes, history forms/notes, intake forms, diagnosis, session notes, course of treatment, prognosis, tests administered (including but not limited to) all questionnaires, answer sheets, testing materials, scores and analysis of test results; x-rays, photographs, electronic and digital files. Please also provide all records regarding (1) treatment for alcohol or drug abuse otherwise covered by 42 C.F.R. Part 2; (2) psychiatric/psychological services and social work, (3) any information or records regarding communicable diseases and infections, which can include tuberculosis, venereal diseases, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or ARC, and (4) all billing and insurance records or reports, correspondence, reports, letters, communications with referring physicians, hospital personnel, the patient, the patient's family members, the patient's attorney(s) and/or agent(s) or any other personnel.

4. This information is to be released for copying purposes to: **Kienbaum Hardy Viviano Pelton & Forrest, P.L.C.** or their agent, at the following address: **280 N. Old Woodward Avenue, Suite 400, Birmingham, MI 48009**

5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the Federal Privacy Rules.

6. This authorization shall be in force and in effect until the conclusion of the pending litigation or claim unless otherwise specified.

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and send it to the hospital, doctor, or other custodian of medical information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

8. I understand that authorizing the release of this health information is voluntary and that I need not sign this form in order to ensure health care treatment, eligibility for benefits, payment or health plan enrollment.

9. I understand that the above is not authorized to withhold production of any records or documentation of any nature concerning any aspect of my treatment or interface with the above.

10. A copy of this authorization is as valid as the original.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on 02/11/2025

(Date)

X



Signature of Patient or Legal Representative

Gerald L Palmer Jr.

Print Name of Patient or Legal Representative